

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020068

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

2619

STATE FILE NUMBER

1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Kansas City

Length of stay in 1b

53 yrs.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

St. Mary's Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Jackson

c. CITY
OR
TOWN

Kansas City

Inside Limits

Yes ☒ No ☐

d. STREET
ADDRESS

(If outside, give location)

4327 Mercier

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

Bernadene

Middle

Fearon

Last

4. DATE
OF
DEATH

Month

Day

Year

5

-

3

-

1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

8-6-1885

9. AGE (last birthday)

77

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

11. BIRTHPLACE (City and state or country)

Germany

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Bernard Uhe

13b. MOTHER'S MAIDEN NAME

Gertrude Boebeker

14. NAME OF HUSBAND OR WIFE

Thomas M. Fearon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

[REDACTED]

17. INFORMANT

Mrs. Bernadine Grawley Shawnee Mission, Mo.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive Heart Failure

6 mos.

DUE TO (b)

Cardiac Hypertrophy

3 years

DUE TO (c)

Atherosclerosis

3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT

☐

20b. SUICIDE

☐

20c. HOMICIDE

☐

20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20e. TIME OF INJURY

Hour

a.m.

p.m.

20f. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

20g. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21. I attended the deceased from

5-11-59

5-3-63

and last saw her alive on 5-3-63.

Death occurred at

11:30

p.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

4320 W. 11th St.

22c. DATE SIGNED

5/4/63.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

5-6-63

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Cemetery

23d. LOCATION (City, town, or county)

Kansas City, Missouri

24. FUNERAL DIRECTOR

24. ADDRESS

Melody-McGilley-Eylar

25. DATE REC'D. BY LOCAL REG.

5-6-63

26. REGISTRAR'S SIGNATURE

Reeth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

P. L. B. Yers

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

1

37182

3

4

1

5

2

6

7

2

8

1

9442X

10

11

12

67-0

13

Dr. P. Byers
4320 Wornall Rd.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.